THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-6347.M5

MDR Tracking Number: M5-04-1743-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 17, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercise, office visits, joint mobilization, myofascial release, nerve conductions, sensory each nerve, somatosens test, and H or F reflex were medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatments listed above were not found to be medically necessary, reimbursement for dates of service from 02-19-03 to 04-17-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of April 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

April 12, 2004

MDR Tracking Number: M5-04-1743-01
IRO Certificate # 5259

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally

established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
58-year-old male with date of injury of ___ while at work moving boxes, up to 300 pounds, with fracture of the coccyx and a hip contusion, with low back, sacral and coccygeal pain. He received treatments (physical therapy) and evaluations from 10/02 through 6/03.

REQUESTED SERVICE (S)
Therapeutic exercise, office visits, joint mobilization, myofascial release, nerve conductions, sensory each nerve, somatosens test, H or F reflex for dates of service 2/19/03 to 4/17/03.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
This patient has no objective neurological deficit. Nerve conduction evaluation, as an extension of the physical exam, offers no literature supported benefit in this setting. This patient has clearly developed chronic pain syndrome as described by Brena. There exists no current and positive peer reviewed literature for effective treatment of chronic pain syndrome with joint mobilization, myofascial release, office visits or therapeutic exercise, on an ongoing basis.